

# AGENDA

## BAY ARENAC BEHAVIORAL HEALTH BOARD OF DIRECTORS CORPORATE COMPLIANCE COMMITTEE MEETING

Thursday, August 7, 2025 at 5:00 pm

Room 225, Behavioral Health Center, 201 Mulholland Street, Bay City, MI 48708

Committee Members: Patrick Conley, Ch Pam Schumacher, V Ch Tim Banaszak Christopher Girard	Present	Excused	Absent	Committee Members: Shelley King Patrick McFarland, Ex Off Robert Pawlak, Ex Off	Present	Excused	Absent	Others Present: BABH: Melissa Prusi, Christopher Pinter, and Sara McRae  Legend: M-Motion; S-Support; MA- Motion Adopted; AB-Abstained
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	Agenda Item	Discussion	Motion/Action
1.	Call to Order & Roll Call		
2.	Public Input (Maximum of 3 Minutes)		
3.	Unfinished Business 3.1) None		
4.	New Business 4.1) Corporate Compliance Report  4.2) Corporate Compliance Committee Notes from the 03/10/25, 05/12/25, and 06/09/25 meetings  4.3) Corporate Compliance Semi-Annual Report  4.4) Quarterly Fraud & Abuse Report to Midstate Health Network (MSHN) – Fiscal Year (FY) 2025 Quarters 2 & 3  4.5) Strategic Initiatives & Dashboard Review		4.1) No action necessary  4.2) No action necessary  4.3) No action necessary  4.4) No action necessary  4.5) No action necessary
5.	Adjournment	M -	S - pm MA

**BAY-ARENAC BEHAVIORAL HEALTH**  
**BABHA CORPORATE COMPLIANCE COMMITTEE MEETING**  
**Monday, March 10, 2025 (1:00 –3:00 pm)**

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager		Melissa Prusi, Rec. Rights/Cust. Serv. Manager	X
Amy Folsom, Clinic Practice Manager	E	Jennifer Lasceski, director of HR	X	Sarah Holsinger, Quality Manager	X
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Ellen Lesniak, Finance Manager, Vice Chair		Joelin Hahn, Director of Integrated Healthcare	X	<b>GUESTS</b>	
Michele Perry, Finance Manager	X	Marci Rozek, CFO	X		
?, Director of IHC					

#	Topic	Key Discussion Points	Action Steps
1.	<p>a) <b>Agenda: Review/Additions</b></p> <p>b) <b>Meeting Notes: Approval of February 10, 2025, meeting notes.</b></p> <p>c) <b>Next Meeting: May 12, 2025 (April cancelled due to CARF)</b></p>	<p>a) No additions to the agenda.</p> <p>b) February 10, meeting approved as written.</p> <p>c) The next meeting is scheduled for May 12, 2025. April meeting cancelled due to CARF Audit.</p>	
2.	<p><b>State-Federal Laws, MDHHS Notices and Regulations</b></p> <p>a) Review of Log and Subject Matter Expert Report Outs</p>	<p>a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.)</p> <p><b>Log No: 410</b> HHS-CMN-SAMHSA Medicare - 42 CFR Part 2 Updates. <u>Working on.</u></p> <p><b>Log No: 412</b> HCBS - restrictions in the IPOS and BTRC. <u>Working on.</u></p> <p><b>Log No: 419</b> WHODAS Announcement. Full implementation Fall 2026. <u>Monitoring.</u></p> <p><b>Log No: 424</b> Coordination of Services between Medicaid Behavioral Health and MI Choice. <u>Needs Review.</u> Send to Melanie for review. Specific to HAB Support Waiver. Nothing was needed to change to comply.</p> <p><b>Log No: 426</b> ICCW Billing. <u>Needs Review.</u> Not billing the code yet. Michelle and Joelin to review.</p> <p><b>Log No: 428</b> Paid Medical Leave. May have changes coming up. Going through the Legislative Process. This was delayed for 10 and under businesses until Oct. 2025. This would include most of our Self D arrangements. <u>Monitoring.</u></p> <p><b>Log No: 429</b> L-24-78. Per a letter of 11/07/2024, BHT including ABA must be provided by individuals meeting the requirements for qualifications outlined in the Behavioral Health and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual. Providers must be licensed by 09/30/2025. Sent to Psychologists on 02/10/2025 for review. Karen will discuss with Psychologists at next supervision. <u>Needs Review.</u></p> <p><b>Log No: 430</b> Wraparound and ICCW Provisional Approval. <u>Monitoring</u> – Not implemented yet as of 02/10/2025.</p>	

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		<p><b>Log No: 431</b> HSW Renewal and 1915(i)SPA Amendment. These were presented at the MDHHS QIC meeting. There are no bulletins yet. HSW was approved in 12/2024 and effective back to 10/01/2024. Also included in this is the 1915(i)SPA Amendment which was effective 01/16/2025. They are working on developing the bulletins that will outline changes. This was sent to Melanie on 3/10/25. Melanie reviewed and stated that this will require several policy changes and recommends that we wait until MSHN changes their policies. <u>Needs Review.</u> Karen, Melanie, Nicole and Joelin to review.</p> <p><b>Log No: 432</b> BH Crisis Provider Training. <u>Needs Review.</u> Joelin, Stacy, Jen, Michelle, and Karen to review. Pertains to the Crisis Team.</p> <p><b>Log No: 433</b> MSHN CFA &amp; P Next Steps Plan. <u>Needs Review.</u> Not a bulletin from LARA or MDHHS but it is Mid-State’s Next Steps Planning for Conflict Free Access and Planning.</p> <p><b>Log No: 434</b> Audio Coverage deletion for 99441-99443. This was issued Feb. 7 and has to do with audio telehealth. This is deleting audio-only for codes 99441-99443 and reporting the place of service as an 02 or 10. We are good with the changes and already have them in place. <u>Closed.</u></p> <p><b>Log No: 435</b> Durable Med Equipment for Children. MDHHS has posted a Notice of Proposed Policy, it is effective, but is a comment period as well. Reviewed at the Committee. Changes to the prior memo are as follows: In the Policy statement before this in 2024, they incorrectly stated that the evaluation of equipment for children, the trial period had to be completed in the home. So, they have reversed that to say that if the child must have a trial period with the equipment, that it is not just limited to the home setting, it can be wherever it needs to be. Also, the option of a digitally drawn signed and dated document consent form from the guardian was removed from that initial memo that went out in 2024, so that has been added.</p> <p><b>Log No: 436</b> 1915i SPA – Approval Letter – <u>Closed.</u></p> <p><b>Log No: 437</b> Update of 1915(c) Waivers –_Already have looked at this to see what needs to happen to comply. <u>Closed.</u></p> <p><b>Log No: 438</b> MDHHS Medicaid Provider Manual Update for 04/01/2025. Reviewed at the committee. Changes include: Updated language to further define payment responsibility under Beneficiary Eligibility, under Peer Support Services, the change has been made that now the peer support person can also supervise, under Prevention Direct Service Models, we were doing some home based and infant mental health services but then the state changed their interpretation and said that if you are already doing home based, you can’t count it as Prevention Direct so we have gone without Prevention Direct. We now have Prevention Direct back because we have the infant and early childhood mental health consultation which was implemented last year through a grant program. A change was also made in the language on Children’s Waiver on Overnight Safety. It now states OHSS is not intended to replace a parent’s or legal guardian of a minor’s obligations and parental rights of minor children living in a family home. Basically, we can have the overnight health and safety but that is not so the parents can be out of the house. Regarding therapy services, these are for OT, PT and speech who are directly contracted with the state to provide the service. Joelin states there was a discussion in the EHR Committee where Dimitry was saying, when talking about separating the authorizations for the OT and PT, that they use the same codes. The state is even saying now, per the instructions on the form, that the person filling out the form for the state must use the modifier to identify if they are OT or PT. This is kind of what Dimitry said we will have to do in separating those authorizations by using the modifier when doing their coding to identify which discipline it is. The</p>	

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		<p>state language says, the form must be submitted with appropriate therapy modifier to distinguish the discipline under which the service is being requested. That is what Joelin put on her email to the group, that if we do go with that kind of change separating those authorizations, that we should use that same language that the state is using. Michele will check to see if modifiers are on the HCPCS list.</p> <p><b>Log No: 439</b> Letter pertaining to Ranges. Per Karen, we have been appealing MDHHS' interpretation of amount, scope, duration, and frequency, and not allowing any ranges within that. It has been a couple of years; Mid-State has gone through two or three appeals on this issue and submitted a response letter on February 27. This letter is basically stating that they are no longer going to entertain this topic. The letter states "This is our final communication regarding this matter. MSHN's position to choose not to comply with this requirement has not impacted our timely submission of required annual reporting to CMS. Therefore, we are requesting these remediations be submitted to MDHHS by March 7. Failure to comply with these requirements will result in contract sanctions." Sarah has scheduled a workgroup for March 17 to address with leadership how we are going to handle this. Sarah states, our plan at this point, is to look at modifying PCE so it no longer allows ranges and then provide education to staff about no longer authorizing services in ranges. Our biggest questions at this point are: What does that education and training look like to staff, how are we going to guide them on what that should look like, are we still authorizing weekly, monthly, quarterly or yearly because once the modifications are made in PCE, staff need to know how to change their process.</p>	
	<ul style="list-style-type: none"> <li>b) Review of CMHA Update on Legislative and Policy Changes</li> <li>c) Review of Compliance Updates/Regulatory Education Needed for Staff</li> <li>d) Process for Ensuring Implementation of Policy Changes</li> <li>e) Updates from CMHAM ED Forum</li> <li>f) MDHHS/PHIP/CMH Contract Changes</li> </ul>	<ul style="list-style-type: none"> <li>b) No review.</li> <li>c) No staff education identified.</li> <li>d) Discussed above.</li> <li>e) Nothing to report.</li> <li>f) Contract Changes Workgroup will be held on Wednesday, March 12 to discuss changes.</li> </ul>	
3.	<p><b>Plans, Policies, Procedures, Assessments:</b></p> <ul style="list-style-type: none"> <li>a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).</li> </ul>	<ul style="list-style-type: none"> <li>a) Karen was asked by Katie to update the Corporate Compliance PowerPoint for staff development and was wondering if we could attach the attestation to the training. Jen states that we probably could and suggested Karen send an email to Katie and cc Jen and they would discuss this at weekly supervision.</li> </ul>	

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	b) Appeals process to comply with releasing records.	b) Melissa just sent out a meeting request to several people to discuss the appeals process to comply with releasing records, including Jesse with regards to the portal.	
4.	<b>Data/Monitoring/Reports:</b> a) Phoenix and Gallery Breach Monitoring b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud /Abuse/ Convictions during Staff Development Days) c) Monitoring of Group Drives for Unsecured PHI Files d) Security Officer Update  e) Ethics/Recipient Rights/Customer Service Update	a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of February. b) No findings. c) No unsecured PHI found. d) February Security Report. Per Jesse, we did not have any security incidences and our Blumera software had found 11 potential findings, all investigated with zero determined to be threats. Karen states we did have one security breach within our system at New Dimension. They sent out tax information to consumers who were employees, and in the window of the envelope it revealed the person’s Social Security Number, name and address. This is enough information to pose a problem. This is the first one that Karen has had to report to DHHS and they had to send out a letter to the consumer, which they did, Karen had to report to Mid-State, which she did.  e) Next ethics committee meeting is scheduled for April. For Recipient Rights and Customer Service, any HIPAA or confidentiality complaint, Karen should have or should be getting the finalized reports and remedial action. Melissa will also follow up with an updated list that are currently pending. Karen asked, when she is the complainant, is it required to send a hard copy of the resolution as well as the email. Melissa states that is not a requirement and she will make sure her staff does not send a hard copy per Karen’s request. Melissa states they are also looking at module updates and changes for Customer Service that don’t necessarily impact any other staff, but they do impact reporting requirement to the state for Customer Service. There are going to be changes to the ABD which will be forthcoming and they will send out information about that as well as updates in the Choice Provider Directory.	

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	<p>f) Report of spot checks for compliance for Self Determination</p> <p>g) Corporate Compliance Activity Report: Policies and Procedures Chapter 13</p> <p><u>March Reports</u></p> <p>h) Quality Review of Medical Records</p>	<p>f) For February, Ben reviewed 7 sets of notes. The bulk of them were good quality but he did have to provide some feedback: one case could use more detail and there was mention of tv in another. We have two referrals that are underway. One has a staff that is not doing their part and the other has a guardian that is not doing their part with paperwork. We have another referral from this month's CLS Committee that should be seamless. He had 4 disenrollments. Two were for lack of utilization, one gained independence and no longer needs CLS and one is now deceased. An Appeal for Self D termination was denied/termination was upheld. We have a transition plan underway with PAO taking over as of 3/14. Ben states he needs to work on a plan for kickoff meeting as Stuart's stopped doing them in-person abruptly. He has asked the person now doing intakes to devise a procedure with him. He also states that he needs to develop a process for getting families their Training Forms and getting them back to me. Some things I need to figure out include virtual Plans, how to ensure follow-through, et cetera. He plans on taking a day next week to get a procedure together for this and for the kickoffs.</p> <p>g) Karen states there are a couple of investigations she is working on. One looks like it is not going to be substantiated, just poor documentation practices. Karen states she is seeing a trend of copy forwarded notes from all different areas of our system and it looks like people are just copying forward or copying and pasting notes from previous sessions. This seems to be across the board, Case Management, Therapists and Direct Care Workers. Karen states a communication will need to be sent out regarding this as it is coming up more and more. Melissa inquires if this could be somewhat indicative of case loads and low staffing and not trying to be deceitful, just trying to get the job done. Karen states that she would agree with this, especially on the clinical side of this. There have not been many that look like intentional fraud other than one substantiation where that happened. Karen has one other that is pending.</p> <p>h) Sarah reported at Leadership meeting also. Basically, the summary shows everything as far as our completion is the same. We had a couple that were below the 95% but they were still increases from FY24Q4. Nothing unusual to report this quarter.</p>	
5.	<p><b>Outstanding Items/Other</b></p> <p>a) Implementation of EVV</p> <p>b) Statewide Credentialing Work Group Updates</p>	<p>a) Nothing to report.</p> <p>b) Jen states that for HR, this has been going okay. Melissa has had several people that we have been able to complete through that process. Stephanie states she was able to download 3 or 4 of the organizational credentialing applications so, hopefully, after today's meeting she will have some that can be officially be approved in the system.</p>	
6.	<b>Adjourn:</b>	<b>The next meeting is scheduled for Monday, May 12, 1:00 – 3:00 pm via MS Teams.</b>	

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7.	<b>Credentialing Committee to follow</b>	Credentialing Committee to follow.	

**BAY-ARENAC BEHAVIORAL HEALTH**  
**BABHA CORPORATE COMPLIANCE COMMITTEE MEETING**  
**Monday, May 12, 2025 (1:00 –3:00 pm)**

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager	X	Melissa Prusi, Rec. Rights/Cust. Serv. Manager	X
Amy Folsom, Clinic Practice Manager		Jennifer Lasceski, director of HR	X	Sarah Holsinger, Quality Manager	X
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Ellen Lesniak, Finance Manager, Vice Chair		Joelin Hahn, Director of Integrated Healthcare	X	<b>GUESTS</b>	
Michele Perry, Finance Manager	E	Marci Rozek, CFO	X		
Nicole Sweet, Director of IHC					

#	Topic	Key Discussion Points	Action Steps
1.	<b>a) Agenda: Review/Additions</b> <b>b) Meeting Notes: Approval of March 10, 2025, meeting notes.</b> <b>c) Next Meeting: June 9, 2025</b>	a) No additions to the agenda. b) March 10, meeting approved as written. c) The next meeting is scheduled for June 9, 2025.	
2.	<b>State-Federal Laws, MDHHS Notices and Regulations</b> a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.)  <b>Log No: 419</b> WHODAS Announcement. Full implementation Fall 2026. Have not heard anything in 6 months or more. <u>Monitoring.</u> <b>Log No: 426</b> ICCW Billing. <u>Needs Review.</u> Not billing the code yet. Marci is not aware of any updates. Michelle and Joelin to review. <b>Log No: 429</b> L-24-78. Per a letter of 11/07/2024, BHT including ABA must be provided by individuals meeting the requirements for qualifications outlined in the Behavioral Health and Developmental Disability Supports and Services chapter of the Medicaid Provider Manual. Psychologists did read the letter that came out. They were confused about whether anything would change for them or not, so Karen will need to look at that again and see if that's true. Karen will discuss with psychologists at next supervision.	

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		<p><b>Log No: 430</b> Wraparound and ICCW Provisional Approval. Not implemented yet as of 02/10/2025. Per Joelin, we are all set on this. Joelin did say the state just sent out a list with some modifiers for all children's services. She will forward to Michelle. <u>Closed.</u></p> <p><b>Log No: 432</b> BH Crisis Provider Training. Pertains to the Crisis Team. Per Joelin, we are all set on this, staff are starting to go through training. <u>Closed</u></p> <p><b>Log No: 433</b> MSHN CFA &amp; P Next Steps Plan. <u>Needs Review.</u> Not a bulletin from LARA or MDHHS but it is Mid-State's Next Steps Planning for Conflict Free Access and Planning. We are talking about potentially looking at Tuscola to provide some case management for the individuals that we have were we provide the direct services.</p> <p><b>Log No: 435</b> Durable Med Equipment for Children. This was reviewed at the committee and changes were made prior to the memo coming out. <u>Closed</u></p> <p><b>Log No: 438</b> MDHHS Medicaid Provider Manual Update for 04/01/2025. We reviewed at last meeting. Joelin had gone through and identified where there were some changes regarding the psychological and neurological testing, peer support services, supervision prevention, service models and children's waiver and HAB waiver for overnight health and safety. Joelin supports closing. <u>Closed.</u></p> <p><b>Log No: 439</b> Letter pertaining to Ranges. Karen thinks we only need to submit an ITR for the authorizations and then that should be all the changes to PCE. Sarah supports closing as she is getting trainings already and must submit that before the next meeting, by June 1. <u>Closed.</u></p> <p><b>Log No: 440</b> Elimination of Pre-Voc Services through HSW. <u>Needs Review.</u> After reading memo, Karen states it looks like if they are on a waiver, they are eliminating pre-vocational services, they say, due to low utilization and a duplication of services. They will allow for a transition for beneficiaries receiving pre-voc services to transition to a similar service, such as 1915i skill building service or out of home non-voc habilitation. The person-centered planning process will be utilized to provide an opportunity to determine what services would best support them and meet their goals and objectives. The deadline to submit list is May 16. Melanie and Nicole to review. Complete Transition by 09.30.2025</p> <p><b>Log No: 441</b> EBP for Childrens Modifiers. An e-mail came out with Modifiers for EBP for children's showing ST for trauma focused CBT and trauma assessment, ST for caregiver, PMTO is a Y3 modifier. <u>Needs Review.</u> Stephanie and Michele to review.</p> <p><b>Log No: 442</b> HCBS Updates 2025 – Delayed Egress and alarms. A memo came out clarifying if they do not have the need for delayed egress and the home has that system in place, that it needs to have a mechanism for those people who do not require that, to have a way to bypass it. Karen states that some of our out of county ones do have that, where there is a keypad, and they give the code to the individuals that don't need the delayed egress. Per the memo, it also must be documented in the plan of service for both those that need it and those that do not need it. The same thing with alarms but they said if not all the doors have alarms and there are some doors that do not have alarms, it is not considered to be a restriction or an intrusion. Melissa states there are some places that only have it on the front door because the back yard is fenced in. Not that it's necessarily locked but fenced in and it's a busy road not too far from the entrance of the home. It's a way of ensuring that people are alerted when someone exits the home. Need to review and update our policies. Provider training on this has been completed. Melanie sent it out to SLT. There is a policy that mid-state has written, and we'll have to look at our policies and make sure that our policies line up. <u>Needs Review.</u> Sent to Melanie for review.</p>	

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		<p><b>Log No: 443</b> Children with IDD and Autism in Child Caring Institutions. It is to clarify that the Medicaid policy allows reimbursement for children with IDD, and those include with autism spectrum disorder who are residing in a child caring institution. These are the things that PIHP may reimburse: Assessments, Behavioral Health Treatment Services/Applied Behavioral Analysis, Child Therapy, Family Therapy, Group Therapy, Individual Therapy, Medication Administration, Med Reviews, OT, PT, Psychological Testing, Speech therapy. Joeline thinks we only have one case where a child is placed in the CCI down in Wayne County. They haven't approached us yet about ABA services, but they did approach us to request the ASD evaluation. This case, in particular, has already had three evaluations and is found to not qualify for ASD or ABA. But if, by chance, this child did qualify, then we would probably need to go into a COFR agreement with Detroit, Wayne CMH for the ABA services. So that is how it will impact us, children with IDD that are placed in a CCI, if they deem that they need ABA and they qualify for it, then they can certainly request that service from us. <u>Needs Review</u>. Heather F., Joelin, Emily, Amanda to review.</p> <p><b>Log No: 444</b> Psychiatric Residential Tx. Facilities-Final Revision. This has been looked at previously. Karen did not see any changes but feels it should be reviewed. Joelin saw that it talked about behavioral treatment plan but didn't see if it was specific to the IDD, SED or both populations. <u>Needs Review</u>. Send to Heather F., Pam, Emily, Kelli, Amanda and Joelin to review.</p> <p><b>Log No: 445</b> ICSS-Proposed Policy- Proposed effective date 07.01.2025. Joelin states we did submit input for feedback on this via Mid-State and Mid-State pulled everybody's input together and submitted it to the department for feedback. One of the main things that Stacey pointed out as an inconsistency is the teams have always been interchangeable, as far as, we try to get staff and then get them credentialed in both because we are serving the adults now too. But in the proposed policy they made it specific that you had to have a peer support specialist for the adults. There were a few other inconsistencies that were embedded that Stacey pointed out to them. We will wait for revisions to be sent back out to us. <u>Monitoring</u>.</p> <p><b>Log No: 446</b> EVV-Home Help and Overlapping Services clarification. It pertains to us, and they are clarifying that anything that is overlapping between home help and CLS or any other service, that whoever gets it in the EVV system first gets to bill it. So here if two or more service visits occurring at the same time are considered overlapping. If a single service visit overlaps with another, it is considered an overlapping visit. Overlapping visits for any home health EVV service will not be paid. The first home health service visits submitted to HH Exchange will be processed. It will not be paid at the same time. So how this would pertain to us, is that some of our providers provide both the home health and the CLS services. <u>Needs review</u>. Nicole, Stephanie, and Michele to review.</p> <p><b>Log No: 447</b> SEDW and MichiCANS/CAFAS update. This was an email that was received from Todd regarding the MichiCANS and the CAFAS. MichiCANS is still required to be completed for all children initially and annually, and as needed. The change here is that the MichiCANS is not required for the determination of eligibility for the SED waiver, initially or annually any longer. Only the CAFAS, PECFAS/DECA will be required to be entered into the scoring tab to support eligibility moving forward. There is not a prescribed workflow for this to occur, but many are completing the screening at intake, moving towards completion of the comprehensive, which should include questions to address CAFUS requirements and if the CAFAS score meets eligibility requirements, the move forward with the SED waiver. They are changing this because they realize that the decision support model is not flagging SED waiver cases</p>	

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		<p>correctly. A letter will be forthcoming. <u>Needs Review.</u> Heather F., Joelin, Emily, Amanda and Pam to review.</p> <p><b>Log No: 448</b> 2025 BH Code Chart Update. OT/PT Codes. Karen added the new code chart in the file and will forward to Sarah and Joelin. <u>Needs Review.</u></p> <p><b>Log No: 449</b> Open Meetings Act to allow remote participation for people with disability. SB 129 Recipient Rights Advisory MDHHS would fall under this. Senate passed. They are waiting to see what the recommendation is. Per Melissa, the Open Meetings Act recipient rights Advisory committee may fall under a Class 3, which would allow attending via tele, like video. We are waiting to hear exactly if that would impact us, including allowing them the right to vote on motions and such or make motions or support motions. <u>Monitoring.</u></p> <p><b>Log No: 450</b> Recipient Rights. SB 142 &amp; 143. SB 143 requires hospitals to give written recipient rights to voluntary admits. They are required to do that for the people that are involuntarily admitted, but this is proposing that the rights be given out in written notice to all individuals admitted to the hospital. SB 142 adds representatives from advocacy groups to have a permanent standing on the recipient Rights Advisory Committee within the MDHHS and prohibiting executive staff from MDHHS from being appointed or serving on that committee. That was referred to the Senate Committee on Housing and Human Services at this point. Require hospitals to give written notice of their rights to voluntary admits. <u>Monitoring.</u></p> <p><b>Log No: 451</b> Autism Diagnosis. HB 4146. The intent is so that autism diagnosis will be more consistent and the proposal requires master level MH professional to have at least 3 years of ongoing professional development and to be supervised by a fully licensed Psychologist before diagnosing ASD. This has been referred to the House Health Policy Committee.</p> <p><b>CMHA Legislation to Watch:</b> HB 4001 Minimum Wage, HB 4002 Labor Benefits (sick time). You can see some of these haven't had any action. We just reviewed HB 4146, Limited License on psychologist diagnosing a patient with autism. These are the ones that CMHA is watching. Karen will stay up to date on these by going to the CMHA Legislative and Policy meetings. When there is movement, she will report them out like the ones reported today. Committee approves this.</p>	
	<p>b) Review of CMHA Update on Legislative and Policy Changes</p>	<p>b) CMHA Policy Updates for April 2025. 1. Fostering administrative efficiencies in Michigan's public mental health system. This is funded by the Michigan Health Endowment Fund. It involves the examination of administrative and paperwork demands placed on the public health system and making recommendations to eliminate those demands that are not tied to any federal regulations, so an advisory group made up of these individuals. They have met several times over the past few weeks to try to guide that effort and try to make some changes at the MDHHS regarding that. Joelin asked, "Does anybody have any idea if these eight pillars being added to the plan of service is a federal mandate? Or is this someone's interpretation at the state? If it is not a federal mandate, that should be given to Mid-State to bring up at this meeting that you just mentioned". Karen is unsure if it is a federal mandate and states it goes along with home and community-based rules, that is where it stems from. But it could be a stricter interpretation of those rules.</p> <p>2. Conflict Free Access and Planning. They have been trying to argue with this from the beginning. They've had meeting with MDHHS and written letters to them. This is just their update and as outlined in earlier committee, has learned that MDHHS has received approval for the HAB waiver, Children's waiver, and SED</p>	

#	Topic	Key Discussion Points	Action Steps
3.	<p><b>Plans, Policies, Procedures, Assessments:</b></p> <ul style="list-style-type: none"> <li>c) Review of Compliance Updates/Regulatory Education Needed for Staff</li> <li>d) Process for Ensuring Implementation of Policy Changes</li> <li>e) Updates from CMHAM ED Forum</li> <li>a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).</li> <li>b) Appeals process to comply with releasing records.</li> </ul>	<p>waiver retroactive back to 10/01/2024. The 1915i waiver has CFAP language has not been approved by CMS. CMHA has reached out to the CFAP team at MDHHS to ensure that we have representation on the design and implementation. This was the April report out. They also discussed the competitive procurements and some talking points.</p> <ul style="list-style-type: none"> <li>c) No staff education identified.</li> <li>d) Discussed above.</li> <li>e) Nothing to report.</li> <li>a) Jen states she has been working with Katie on employee attestations and has a meeting tomorrow with Katie to follow up and see where we are with that.</li> <li>b) Karen and Melissa agree that this has been completed and can be taken off the agenda.</li> </ul>	
4.	<p><b>Data/Monitoring/Reports:</b></p> <ul style="list-style-type: none"> <li>a) Phoenix and Gallery Breach Monitoring</li> <li>b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud /Abuse/ Convictions during Staff Development Days)</li> <li>c) Monitoring of Group Drives for Unsecured PHI Files</li> </ul>	<ul style="list-style-type: none"> <li>a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of March and April.</li> <li>b) Jennifer reported no exclusions/debarments for April and May. Stephanie reported no exclusions/debarments.</li> <li>c) No unsecured PHI found.</li> </ul>	

#	Topic	Key Discussion Points	Action Steps
	<p>d) Security Officer Update</p> <p>e) Ethics/Recipient Rights/Customer Service Update</p> <p>f) Report of spot checks for compliance for Self Determination</p> <p>g) Corporate Compliance Activity Report: Policies and Procedures Chapter 13</p>	<p>d) In March we had one actual security incident that was resolved. We had a malicious program that was a fake PDF reader. It was removed from our file server. It had gotten on there through a user's group drive. Our security software had spotted the unusual activity, contained it, and we were able to remediate all the instances of it. It did not get into any files; it didn't cause any sort of breach, or it didn't steal any data. It was just simply there, and we were able to remove it, remediate it from the server and rebuild the user's VDI sessions. That is a big win for our security software for being able to detect that and help us remediate the issue.</p> <p>e) Melissa states there was an Ethics meeting on 04.30.2025 where an issue was discussed where a supervisor provided direction to an employee to alter and/or delete documentation and/or dates that can recreate something, so it fell within a standard. The employee did not do that, so that's a great thing but there were a lot of discussions about that which were very helpful. Updating the Recipient Rights/Customer Service, Melissa sent Karen a summary of complaints regarding potential HIPAA confidentiality allegations, some of which are completed and some that are currently pending. Regarding Customer service there are several updates looking to address HSAG reviews throughout the state regarding ABD citations and various other things. Those things will be coming forward when we know exactly the changes that are going to be made. Specific things regarding documenting or determining when an ABD is prepared versus mailed out. So, we are going to have to somehow address this in policy what time things are mailed out versus ABDs being sent out. We will address that situation in policy and then make sure everyone is educated. An example would be, if an ABD is created and prepared to be mailed after 5:00 pm, there is no way it is getting mailed on that date. So, we will have to make sure staff are aware if you are getting ready to mail an ABD, and it is after hours or if you are preparing one that you know will be mailed after hours because it hasn't even been reviewed yet by a supervisor, then the mail date needs to be for the next day.</p> <p>f) Ben submitted his report on Self D monitoring. He looked over 10 different people's individual progress notes. He provided feedback regarding one person's notes, and it is really about the content of the notes not being CLS, so he did training for that. He has gotten several referrals. He has three referrals that he is working on and looking at a staff for another individual.</p> <p>g) This is usually brought to this meeting before being brought to the Board Committee but because of the quarterly schedule, Karen had to bring it to the Board first. So, this is a summary of the Quarterly report that was submitted to MSHN that will then go on to the OIG. We had one investigation. It was a product of a random audit that was completed where there were notes from staff to staff and day to day that appeared to look the same. Karen did an investigation, and the employer, which is the guardian of the</p>	

#	Topic	Key Discussion Points	Action Steps
	<p><u>April &amp; May Reports</u>  h) Email Security Phishing Drills</p>	<p>individual who receives the services and was a Self D arrangement, confirmed that they all received the services on the days that we were looking at. You couldn't really determine that they were copied, even though the wording was exactly the same. So, Ben did provide some training to that guardian and the guardian was going to train her staff on that. Karen confirmed that was completed in April, so there were really no findings on that one. The rest are all our MEV audits. They were all scheduled MEV audits. We did the Arnold Center, we did our Direct Operated CLS, we did Disability Network of Mid-Michigan. We completed an audit on Stewart Wilson, and when I say we, I mean Sarah's department. Out of MPA, List and Saginaw Psych, we looked at a total of \$104,000 worth of claims. Of those, we had to recover \$913. None of these were immediately reportable to the OIG because they were all under that threshold.</p> <p>h) Phishing test results. There are two reports, one for March and one for April. Our March phishing test results, we had 10 people click and we had 71 people report. The last three phishing tests the trend line is right around the industry average with two of them being below. Januarys was slightly above average, and our reporting numbers are holding roughly steady if you were to draw a trend line on them. The phishing email that was sent out stated that your duo service is temporarily suspended due to intermittent internet connectivity, and they want you to click the button that says re-authenticate. Our April report is, we had 12 people click and had 54 people report. The phishing email sent out was notifying people of mandatory MFA on the Office 365 account and includes a QR code for you to scan. It tells you that it is going to be enforced by April 30, it is from IT at BABHA.org. The red flags included a banner that says the email appears to come from a BABHA address but includes the warning that this message has originated from an outside source. The banner states that we are implementing MGA when we already had it in place for several months. It gives you a short time frame to avoid a negative consequence, has a generic email signature which we do not do and has a QR code to take you to an unknown location. You really should not be using those in general. Karen states the board was expressing quite a bit of concern about our low rate of people reporting those and Jesse did a good job of saying sometimes they will just delete it but our preference is that we would want people to the reporting it even if they are pushing the phishing or even if they're deleting it because that way we can show that people are actually picking up on the fact that those are bad emails. Jesse states that his team is trying to come up with a good idea on how to incentivize people to report them. But with our current financial situation at BABH, we want to be cost sensitive to that. So, the best way to do that might be a point system and put people in a drawing for something. Heather F. states that this last test is the first time that she has reported, and it is only because she repeatedly heard you say to click into the email. Before, she was afraid to click into it thinking that that would cause a problem but if you don't click into it, you can't report it as the phishing button doesn't come up. So, she would just delete them or email IT. So, it could be just that people aren't really understanding and don't want to click on it, so they delete it. Sarah states she didn't realize the goal was to report them, so thinks that more education to staff about what the expectations are and what the hope is versus incentivizing and would start with an education piece. Jesse states we can certainly send out another education to staff letting them know it is all</p>	

#	Topic	Key Discussion Points	Action Steps
	<p>i) Provider Network Site Review Summary</p> <p>j) Verification of Medicaid Services Direct Operated/Contracted Services Providers</p> <p>k) Plan w/in 15 Days; Health Care Coord; Crisis Planning; Medical Necessity</p>	<p>right to click on it to report it, just don't click on the link or attachment. Joelin asks if anyone is aware of doing recent work with Viper or MiHIN as she received an email thanking her for creating an account. She doesn't use that tool, she uses Care Connect 360. Jesse states Theresa was receiving the phishing requests from that email and it appears as though the email from MiHIN and Viper is a legitimate email. He states it does have some fishy looking stuff in it, so thinks people were right to be cautious of that email.</p> <p>i) PI Summary Report FY25Q1. Plan of service given within 15 days, we had all providers except for one increased in compliance, so we are seeing improvement. The second part of that is the plan of service notification method was blank in the middle. We continue to see that staff aren't updating the sent link in the plan of service. There may have been some PCE changes though with that, so hopefully, we'll see that starting to produce either an alert or a To Do item so that staff are updating and attaching information that we need there. The last graph just shows the numbers, so we can see where the percentages come from. If it's a result of 50 plans or, in the case of Bay Direct, you're looking at almost 400 plans for that quarter. The same with MPA running about 270 compared to Saginaw Psych at 66. So, just the difference in the total quantity of plans. Next, here is the evidence of primary care coordination. We saw some increase and decrease over the last quarter. We have had some that have had some pretty significant decreases. We are really just looking at the coordination of care form that is in PCE. We are seeing that people are filling out the universal consent, but that is not the coordination of care. The coordination of care form actually has diagnoses and program and medication information which is what the state is looking for. We talked about that at the meeting last week and how to address whether a consumer has a primary care and what to do if they don't. The things we were seeing, just as quality issues, when the pre-plan and plan of service are occurring on the same day it needs to be specified and we were seeing that there were not explanations for that and then a lot of unsigned or expired documents which is some of what Karen was addressing during her compliance report. Those have been addressed either through a corrective action plan or through Karen meeting with the providers individually to go over those concerns. Karen states that Theresa sends out the unsigned document report monthly, and when a supervisor does not respond, or hasn't made corrections, then she forwards the report to Karen as well. So, Karen is in the process of going out and talking to some staff and figuring out why their documents are still unsigned.</p> <p>j) See Above</p> <p>k) See Above</p>	



**BAY-ARENAC BEHAVIORAL HEALTH**  
**BABHA CORPORATE COMPLIANCE COMMITTEE MEETING**  
**Monday, June 9, 2025 (1:00 –3:00 pm)**

MEMBERS	Present	MEMBERS	Present	MEMBERS	Present
Karen Amon, Comp.& Privacy Officer, Chair	X	Heather Friebe, Clinical Program Manager	X	Melissa Prusi, Rec. Rights/Cust. Serv. Manager	X
Amy Folsom, Clinic Practice Manager	X	Jennifer Lasceski, Director of HR	X	Sarah Holsinger, Quality Manager	X
Lynn Meads, Medical Records, Recorder	X	Jesse Bellinger, Security Officer	X	Stephanie Gunsell, Contract Manager	X
Nicole Sweet, Director of IHC	X	Joelin Hahn, Director of Integrated Healthcare	X	<b>GUESTS</b>	
Michele Perry, Finance Manager	X	Marci Rozek, CFO			

#	Topic	Key Discussion Points	Action Steps
1.	<b>a) Agenda: Review/Additions</b> <b>b) Meeting Notes: Approval of May 12, 2025, meeting notes.</b> <b>c) Next Meeting: July 14, 2025</b>	a) No additions to the agenda. b) May 12, meeting approved as written. c) The next meeting is scheduled for July 14, 2025. There has been a change in the transition plan, the Corporate Compliance role will be extended until the beginning of August, end of July. Karen will still be here for the July 14 <sup>th</sup> CC meeting in the CC role.	
2.	<b>State-Federal Laws, MDHHS Notices and Regulations</b> a) Review of Log and Subject Matter Expert Report Outs	a) Karen and the committee reviewed the log: (Log can be found under Corporate Compliance Reg tab. Go to issue # to see what was talked about and what needs to be reviewed.)  <b>Log No: 419</b> WHODAS Announcement. Full implementation Fall 2026. Have not heard anything in 6 months or more. <u>Monitoring.</u> <b>Log No: 426</b> ICCW Billing. The code is now in the system. Can be <u>closed.</u> <b>Log No: 429</b> L-24-78. Per a letter of 11/07/2024. The psychologists didn't thing this was going to affect us at all when Karen talked to them relating to the ABA credentials. Karen will go back and look at this to see if she agrees. <b>Log No: 433</b> MSHN CFA & P Next Steps Plan. At the QIC meeting last week, again, they brought this up and it is going forward but nothing that would help us plan. Karen states we have been talking internally about how we are going to address this. We have certain areas within our organization that we have to focus on, which is our Horizon Home. We are doing their case management as well. That would be an area that we would have to address if they go forward with the same plan and it doesn't sound like they are changing	

#	Topic	Key Discussion Points	Action Steps
		<p>their ideas about that piece of it. So, we have talked about contracting with a different CMH. In particular, we have talked about looking at Tuscola as they are our closest partner, and we already have a working relationship with them on other cases. So, that might be our best bet but must look at case management also with North Bay CLS staff as well and do we look at it as a choice from the consumer if they want to keep their case management or if they want to keep their CLS through our agency. So, there is still quite a bit of talk regarding how we are going to implement Conflict Free Access and Planning and now with the new proposed procurement for the PIHPs, I'm wondering if that would change in any way the state's thought about how to implement Conflict Free Access and Planning. Karen states Chris is advocating, along with the other CMH's CEOs and CMHA that this goes outside the realm of what is for community mental health.</p> <p><u>Monitoring.</u></p> <p><b>Log No: 440</b> Karen closed but wanted to let committee know. It was the elimination of pre-voc services through the HAB waiver and in talking with finance as well as Nicole, we never have offered pre-voc services so this really doesn't affect us at all.</p> <p><b>Log No: 441</b> EBP for Childrens Modifiers. Michele states she just needs to know which modifiers we will be using so she can get them in the system. They don't need to go back to April 1, we just need to use them going forward. Michele sent Joelin an email asking which modifiers we will need in the system. <u>In Progress.</u></p> <p><b>Log No: 442</b> HCBS Updates 2025 – Delayed Egress and alarms. <u>In Progress.</u> Melanie thinks that we need to look at our policies and make sure that we have covered this under restrictions. The providers have already been trained. Karen to review the policies related to restrictions. Related to this, there is a new behavior treatment technical requirement coming out and there are some meetings and trainings coming through in the next couple of weeks.</p> <p><b>Log No: 443</b> Children with IDD and Autism in Child Caring Institution. The only CCI we have is the juvenile detention center and we are already providing services to it. Joelin needs to check on what to do for COFR arrangements. <u>In Progress.</u></p> <p><b>Log No: 444</b> Psychiatric Residential Tx. Facilities-Final Revision. Joelin states she is now very familiar with psychiatric residential treatment facilities, and we haven't been able to get anyone in because their waiting list is so long. <u>Monitoring.</u></p> <p><b>Log No: 445</b> ICSS-Proposed Policy- Proposed effective date 07.01.2025. Not yet finalized. We did submit feedback to MSHN. <u>Monitoring.</u></p> <p><b>Log No: 446</b> EVV-Home Help and Overlapping Services clarification. This was clarifying that you can't have home help and CLS services at the same time and whoever gets the billing into the system first will get paid. However, we have some unique situations where there might be two staff on, and they are providing two services that might potentially overlap. <u>Needs review.</u> Nicole, Stephanie, and Michele to review.</p> <p><b>Log No: 447</b> SEDW and MichiCANS/CAFAS update. Karen's understanding of the update is that everyone still must do the MichiCANS but to determine eligibility for the SED waiver, we are using CAFAS, PECFAS and DECA, not MichiCANS. Joelin has checked with Emily to assure that there are some trained CAFAS and PECFAS staff and will get with Pam and Heather as well. <u>In Progress.</u></p> <p><b>Log No: 448</b> 2025 BH Code Chart Update. OT/PT Codes. Michele states we are not going to bundle these as it is not beneficial because the only provider that uses these is Paramount. <u>Closed.</u></p> <p><b>Log No: 449</b> Open Meetings Act to allow remote participation for people with disability. SB 129 Recipient Rights Advisory MDHHS would fall under this. Senate passed. No movement. <u>Monitoring.</u></p>	

#	Topic	Key Discussion Points	Action Steps
3.	<p><b>Plans, Policies, Procedures, Assessments:</b></p> <p>b) Review of CMHA Update on Legislative and Policy Changes</p> <p>c) Review of Compliance Updates/Regulatory Education Needed for Staff</p> <p>d) Process for Ensuring Implementation of Policy Changes</p> <p>e) Updates from CMHAM ED Forum</p> <p>a) Status of Employee Attestations/Time for new ones (End of Summer/early fall).</p>	<p><b>Log No: 450</b> Recipient Rights. SB 142 &amp; 143. SB 143 requires hospitals to give written recipient rights to voluntary admits. They are required to do that for the people that are involuntarily admitted, but this is proposing that the rights be given out in written notice to all individuals admitted to the hospital. SB 142 adds representatives from advocacy groups to have a permanent standing on the recipient Rights Advisory Committee within the MDHHS and prohibiting executive staff from MDHHS from being appointed or serving on that committee. That was referred to the Senate Committee on Housing and Human Services at this point. Require hospitals to give written notice of their rights to voluntary admits. <u>Monitoring.</u></p> <p><b>Log No: 451</b> Autism Diagnosis. HB 4146. The intent is so that autism diagnosis will be more consistent and the proposal requires master level MH professional to have at least 3 years of ongoing professional development and to be supervised by a fully licensed Psychologist before diagnosing ASD. This has been referred to the House Health Policy Committee. <u>Monitoring</u></p> <p>b) Discussed above.</p> <p>c) No staff education identified.</p> <p>d) Discussed above.</p> <p>e) Nothing to report.</p> <p>a) Jen states she met with Katie, she had created an MS forms survey attestation and had sent that to both. There were some questions for IT regarding this.</p>	
4.	<p><b>Data/Monitoring/Reports:</b></p> <p>a) Phoenix and Gallery Breach Monitoring</p> <p>b) Exclusion/Debarment – Officers, Employees, Contractors, Vendors (Annual staff Attestation for Fraud /Abuse/</p>	<p>a) Monthly monitoring completed; Lynn reported no security breaches in Phoenix or Gallery for the month of May.</p> <p>b) Jennifer reported no exclusions/debarments. Stephanie reported no exclusions/debarments.</p>	

#	Topic	Key Discussion Points	Action Steps
	<p>Convictions during Staff Development Days)</p> <p>c) Monitoring of Group Drives for Unsecured PHI Files</p> <p>d) Security Officer Update</p> <p>e) Ethics/Recipient Rights/Customer Service Update</p> <p>f) Report of spot checks for compliance for Self Determination</p>	<p>c) No unsecured PHI found.</p> <p>d) For May, we did not have any security breaches that needed to be cleaned up. Our systems found a total of 18 findings. All of them were false positives. Last month, in April, towards the end of the month, we did have one finding that was not a false positive and that got cleaned up by the system. That was another instance of the malware item PDF skills.EXE. So, our security software saved us for the second month in a row from having an issue and clean up went just as good as it did last month. No other instances of any security issues to report beyond that.</p> <p>e) There has been no Ethics meeting since the last time Melissa reported. With regards to Recipient Rights, the complaints that are overlapping with Karen, they are both aware of and Melissa is not aware of any other complaints. For Customer Services, we are looking to find another Medicaid Fair Hearing Officer because Kimberly Cereske is going to begin cross training and start doing recipient rights. Anyone that is doing recipient rights cannot do Medicaid Fair Hearings. As you know, Jackie is coming into and transitioning to the Recipient Rights/Customer Services Dept, so she will also be going through training on both recipient rights and customer services so she also cannot do the Medicaid Fair Hearings. Mr. Pinter will designate a Medicaid Fair Hearings Officer who will handle those issues and then we will get both Jackie and Kim trained and will move forward through the transition. Modules, they are looking to change things with the ABDs to meet the HSAG requirements and a guidance will be going out to everyone regarding ABDs. We are also looking at tag lines being updated and implemented and there needs to be some change to the IPOS language when it prints out, there may be some re-wording needed.</p> <p>f) Self Determination Report. Ben reports for the month of May, he reviewed 14 sets of progress notes. The bulk of them were good. He had two families where he provided feedback on the content of what CLS is. The other notes had robust details for the most part and had CLS appropriate activities that were in line with the goals of the person served. EVV is about halfway done, and this is, of course, ensuring that the staff are billing at the places that they mention in their notes, thanks to the GPS component. He had 3 referrals fore the month of May and all of them are underway aside from one exception where the staff has yet to fill out their paperwork. We had three people that were over utilizing but they were all minimal and have plans to dial their hours back. There was only one exception, who was over by 54 hours, so he is trying to work that out to have it become balanced. The others that were over, were minimal hours like 14 hours. He says that overall, over utilization seems to be lessening more and more, given the reports received from Stewart Wilson.</p>	

#	Topic	Key Discussion Points	Action Steps
	<p>g) Corporate Compliance Activity Report</p> <p><u>May Reports</u></p> <p>h) Ability to Pay Compliance Rate – Deferred from last month.</p> <p><u>June Reports</u></p> <p>i) Quality Review of Medical Records</p>	<p>g) Karen has had very little investigation activity. She has had one investigation that she and Melissa participated on, and it really did not determine fraud. It was some bad/improper documentation issues having to do with trying to correct compliance issues which leads into the next topics:</p> <ul style="list-style-type: none"> <li>• Trend of overdue assessments and IPOS with multiple interim plans and no established medical necessity was discussed and documents being done out of order. Late documents can prevent consumers from receiving medications if interim plan is not done.</li> <li>• Interim Plan guidelines in question; one interim plan, the rest are exceptions and need a reason?</li> <li>• Reimbursement and recoupments possible if there is no valid assessment to determine medical necessity and services aren't being provided appropriately.</li> <li>• Sanctioning or doing takebacks are an option to look at for overdue documents with no authorizations for services provided.</li> <li>• Monthly reports regarding documentation are sent out. Reports are available to providers in Phoenix. Staff receive alerts for overdue documents.</li> <li>• Whether appointments should be cancelled if there are no authorizations was discussed.</li> <li>• Regarding consumers showing up for Med appts but not keeping meetings with case holders, should an ABD automatically be sent when a person misses their planning meeting and should it be sent to all persons involved with case. Outreach should continue after ABD is sent.</li> <li>• Action Proposed: Come up with a plan, give staff guidance, have approx. a 4 month start up time and a cutoff date. If issues are found after this date, we would start doing takebacks.</li> <li>• Action Proposed: Remedial action, some kind of training, put things in writing, review at leadership and PNOQMC, then let it be known that without control of this using the tools available, we will have to look at recoupments.</li> <li>• Should we be reducing the amount of documents supervisors must review? This was discussed previously with a divide amongst managers and supervisors whether this should be done. Should this topic be revisited?</li> </ul> <p>h) Ability to Pay Compliance Rate. Michele states we are at a 94.2% compliance of ATPs. Our average non-compliance is 5.8%. Michele states the finance dept is staying on top of this. They are sending emails to case managers to get them done.</p> <p>i) Quality Review of Medical Records Summary Report. During FY25Q2, 92% of the required trainings were completed. Analysis determined that 10 out of 90 records reviewed found that the Coordination of Care Form wasn't completed, or it was expired, which resulted with a score of 89%; this is a 2% decrease from</p>	

#	Topic	Key Discussion Points	Action Steps
		<p>FY25Q1. There were 23 out of 93 records reviewed that indicated that the Assessment was unsigned, had blank items, or had the incorrect designation marked. This resulted with a score of 75%, which is a 22% decrease from Q1. There were 6 out of 92, or 93%, the plan of service didn't contain complete information, so there were things that were left blank on that. Six out of 68 records reviewed or 91%, showed the Review of Progress was either completed late or wasn't completed at all. That is something that we have been monitoring. For the Termination /Transfer section, there were a lot that were significantly lower but after reviewed, there was a staff that was marking "no" for things that should have been marked as "na". So, staff education has been done regarding this issue. Joelin asks if the report that Sarah just went over if the reviews were done internally. Sarah states that these are done internally for this report. Karen says that if we are thinking that we need some kind of reporting on that to help us out, the best place to talk about that would be at Data Governance Meeting. That way Joelin could attend, and the other parties that are involved in it could attend and then that would be a good place to have everyone on board talking about how to gather that information, what needs to be gathered and Jesse is the facilitator of that meeting. That is probably where we should have that discussion, if it is needed. Sarah states that from her recollection from the past, that we had done a report like that similarly when we were starting to have issues with this. Greg and Lisa met with Sara recently to go over reports that Sarah had requested to archive, things we hadn't used in a long time. Sarah thinks if that was one of the reports, it could be something that they could resurrect. Karen states the next Data Governance Meeting is May 16<sup>th</sup> at 9:30 am. Jesse will put this on the agenda.</p>	
5.	<p><b>Outstanding Items/Other</b> a) Implementation of EVV</p>	<p>a) There was an issue that came up regarding two different designations. Jesse states this issue is in progress. Apparently, there is a difference between a provider portal and a payer portal. We should be doing some stuff in a payer portal but we have been doing all of our EVV stuff in a provider portal. We allegedly need both because we have some contracted services and some internal services. We are in the process of figuring out how to access both sides of it and make sure that all of the stuff that we're doing is getting done correctly. We also had another issue where some providers that we contract with didn't have anything showing up in the system. We've been working with them and sending out some communications to see if they are using the system like they are supposed to or what is going on.</p>	
6.	<p><b>Adjourn:</b></p>	<p><b>The next meeting is scheduled for Monday, July 14, 1:00 – 3:00 pm via MS Teams.</b></p>	

Scale for Status Rating: Good-Improved-Fair-Poor

**COMPLIANCE MONITORING**

Monitoring	Status at Last Report	Status as of this Report	Comments
Electronic health record security breach monitoring (for violations of role-based security)	Good	Good	No findings.
Sanctioned provider (exclusion/ debarment) checks for employees and officers, contracted clinical service providers and selected vendors	Good	Good	No findings.

Auditing	Status at Last Report	Status at this Report	Comments
Contracted Service Provider Site Reviews	Good	Good	During FY25Q1 and FY25Q2 there were 14 site reviews completed. These reviews were for ABA providers, inpatient psychiatric hospitals, and vocational providers.
Record Reviews	Improved	Fair	FY25Q1- 89% of records assigned were completed. 85% trainings were completed. Areas falling under the threshold included Coordination of care not evident, IPOS not reviewed for effectiveness within the time frames indicated. This was an improvement from FY24 Q4. FY25Q2- 86% of records assigned were completed. 92% trainings were completed. Areas falling under the threshold included the Termination/transfer sections were not completed accurately, IPOS not reviewed for effectiveness within the time frames indicated, all sections of the IPOS were not completed, all sections of the assessment were not completed and coordination of care not evident. Overall a decrease from FY25Q1.
Verification of Medicaid services provided for direct operated programs & contracted service providers	Good	Good	Forty two MEV audits were completed for Q2-Q3 for the Ancillary Providers. This includes ABA, CLS and FMS and Dietary providers. Eight MEV audits were completed for Q2-Q3 for Primary providers including Bay Direct operated. Ancillary services reviewed were \$492,015.06 of claims with a recoupment amount of \$678.64. However, some are still have not had a finalized amount of recoupment, so this may be slightly higher. The Primary provider services reviewed \$107,096.96 of claims with a recoupment of \$1,527.07.  Self Determination Coordinator has been completing monthly spot checks for MEV and quality in documentation and reporting to the CCC.

RISK ASSESSMENT			Status of Action Plans
Dep't of Justice Compliance Program Eval	Triennial	Next eval due in 2025	The 2022 self-evaluation was completed during the reporting period as scheduled. BABHA scored 99-100% on 34 out of 43 standards (80%). Of the 9 standards warranting improvement, action steps include more training for supervisors on compliance, strengthening training on policies and procedures, and post implementation evaluation of process changes to ensure regulatory compliance is fully actualized. Training for Supervisors has been developed and individual new supervisors have had one on one training. To address

RISK ASSESSMENT			Status of Action Plans
			education on policies and procedures this has been incorporated in the Relias System.
Fraud/Abuse Risk Assessment	Triennial	Next Assessment due 12/2026	Completed and presented to CCC 12/2023. Presented and Approved by HCICC 1/2024. The MEV reviews have been completed as scheduled and the increased amount of MEV's being conducted has been implemented. The external providers have been restricted from being able to do stand alone authorizations. A report for expired IPOS is available to external providers now that everyone is on PCE. The Self Determination Coordinator has provided monthly MEV and provider education and reported this to the CCC. A training schedule has been developed and staff development has assigned children's training to staff who need the hours. The EVV system has had a soft launch and is being implemented. IPOS training continues to be missed. Additional training has been conducted at Leadership Meetings and PNOQMC. The children's team has been educated on how to run reports on the training hours within Relias.
Security Risk Assessment	Annual	Completed July 2024	New Plan includes exploring new options to limit device access to the cloud based E.H.R. Access to PHI is protected by user name, password and 2 factor authentication. Explore ways to improve monitoring unauthorized attempts to access our facilities. Security Risk Assessment due by end of July.

EDUCATION		
Persons Served	Frequency	Status
Consumer Council-Bay Consumer Council-Arenac	Annual/PRN	Website contains Fraud Abuse and Privacy education. Consumer Council will be educated in September. Self Determination education for new consumers has begun to be tracked and reported to MSHN as well as the 5% EOB's that are sent out annually.
Board of Directors	Frequency	Status
Full Board Corporate Compliance training	Annual	Completed June 19, 2025
Additional compliance information provided for Board of Directors:		
<u>Date</u>	<u>Audience</u>	<u>Topic</u>
2/6/2025	CCC Board Members	CC Semi Annual Plan, Annual Litigation Report, CC Plan, Dashboards for Privacy and Fraud, OIG work plan.
5/1/25	CCC Board Members	CC Dashboard, MSHN MEV Findings, Quarterly Fraud and Abuse report for FY25Q1 and FY25Q2.

Supervisors	Frequency	Status
Standing compliance agenda item on Bi-Weekly Leadership meetings	Monthly	Completed
Supervisor-specific corporate compliance training	Annual	Developed initial training and provided training via email to Supervisors.

Additional Educational Activities for Supervisors:

<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>
None			

<b>Employees</b>	<b>Frequency</b>	<b>Status</b>
New employee orientation to corporate compliance, privacy and confidentiality	Monthly	Completed every month.
Corporate compliance training	Annual	KA completed Telehealth Updates on 12/5/24.
Privacy/security/confidentiality training	Annual	Arenac Staff on Privacy on 12/11/24.
Corporate Compliance Plan in-service	Annual	HCICC approval 6/3/24, Board approval 6/20/24 and staff training completed in July.
Email security drills (by Security Officer)	Quarterly	<p>Email security drills were performed in May, June, and July.</p> <p>In May, 263 recipients received the same email from <a href="mailto:IT@babha.org">IT@babha.org</a> which included a QR code with a prompt that a mandatory Multi-Factor Authentication on their Office 365 Account. 29 staff reported this as a phishing email through the “Phish Alert Button” [PAB] and 12 staff clicked, which is below the industry standard.</p> <p>In June, 267 recipients received the same email from Zoom <a href="mailto:noreply@meet-zoom.us">noreply@meet-zoom.us</a> indicating that a cloud recording from the “Risk Committee Meeting” was available if they clicked the “View Detail” button in the message. 88 staff reported this as a suspicious email through the PAB feature, while 26 staff clicked and attempted to access this recording. This is two times more than the industry standard.</p> <p>In July, 267 recipients received one of three randomly selected phishing test emails. 77 staff reported this as a phishing email, and 16 clicked on the email. This is also above the industry standard. The IT department is considering additional education for all staff to help increase the agency’s email security.</p>

Additional Educational Activities for Personnel:

<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>
12/11/24	Arenac Staff	Privacy	In person
4/8/25	All staff and Primary Providers	How to document Homelessness in demographics	email
7/9/25	Adult MI Team	Compliance with Documentation.	In person

<b>Contracted Service Providers</b>	<b>Frequency</b>	<b>Status</b>
Corporate Compliance Training for Residential/ Community Living Support Providers	Annual	Completed 4/30/25
Corporate Compliance Training for Vocational Providers	Annual	Needs to be Completed
Corporate Compliance Training for Primary Providers	Annual	Needs to be completed

Corporate Compliance Training for Autism Providers	Annual	Completed 4/8/25
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Additional Educational Activities for Contracted Service Providers:				
<u>Date</u>	<u>Audience</u>	<u>Topic</u>	<u>Type</u>	
4/8/25	ABA Providers	Video and Security Cameras	In person	

Corporate Compliance Staff & Leadership	Frequency	Status
Review of Regulatory Changes	Monthly	Completed
Review of Medicaid and General Fund Contract Boilerplate and Attachments	Yearly	In process
Review of CMS Office of Inspector General [Regulatory Compliance] Work Plan	Yearly	1/13/25

Educational activities for compliance leadership:				
<u>Date</u>	<u>Audience</u>	<u>Topics</u>	<u>Type</u>	
1/5/24	Karen Amon	Telehealth Updates	Webinar	

Report Prepared by:  
Karen Amon, LMSW  
Director of Healthcare Accountability

Date: July 14, 2025

BEHAVIORAL HEALTH

Date Initiated	Source of Activity	Service/ Program	Provider Name	Brief description of issue/allegation	Codes Involved	# of Claims Reviewed	# of invalid Claims	# of Staff	# of Cons	Total Paid Amount Related to Complaint/ Activity	Overpay Identified?	Potential Fraud?	Date Referred to MIOHSIG	Total Over-payment	Disposition	Date Resolved
04/17/25	Audit - Scheduled		James Stevens	Scheduled audit. Previous therapist did not sign assessment and did not complete IPOS. New therapist and supervisor created documents based on progress notes and meeting documentation from previous case manager. These were not billed so no recoupment warranted.	90832	2	0	1	1	\$0.00	No	No	NA	\$0.00	Closed-No findings	05/05/25
04/17/25	Audit - Scheduled		Megan Smith	Scheduled audit. Previous therapist did not sign assessment and did not complete IPOS. New therapist and supervisor created documents based on progress notes and meeting documentation from previous case manager. These were not billed so no recoupment warranted.	90832	2	0	1	1	\$0.00	Yes	No	NA	\$0.00	Closed-No findings	05/05/25
03/17/25	Audit - Scheduled	Behavioral Health/Analyst	Linda Winningham	Scheduled MEV audit		78	4	Various	Various	\$ 8,841.00	Yes	No	NA	\$ 537.00	Closed-Recovered	07/22/25
03/10/25	Audit - Scheduled	Behavioral Health/Analyst	PARAMOUNT	Scheduled MEV audit		125	3	Various	Various	\$ 10,589.56	Yes	No	NA	\$ 713.56	Closed-Recovered	07/22/25
03/08/25	Audit - Scheduled	Vocational	NEW DIMENSIONS	Scheduled MEV audit		13	1	Various	Various	\$ 365.37	Yes	No	NA	\$ 2.74	Closed-Recovered	07/22/25
03/08/25	Audit - Scheduled	Community Living Service Provider	PAO	Scheduled MEV audit		17	8	Various	Various	\$ 1,647.50	Yes	No	NA	\$ 922.60	Closed-Recovered	07/22/25
03/08/25	Audit - Scheduled	Fiscal Intermediary	Stuart Wilson	Scheduled MEV audit		125	3			\$ 16,422.62				\$ 234.72	Closed-Recovered	07/22/25
05/23/25	Audit - Scheduled	Home and Community Based - Personal Care	Hickory Hollow Specialized Residential	Scheduled MEV audit		34	2			\$ 19,882.17				\$ 979.20	Closed-Recovered	07/22/25
Totals										\$57,748.22				\$3,389.82		

Year ● 2025

